Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: December 11, 2023	
Inspection Number: 2023-1128-0004	
Inspection Type: Critical Incident	
Licensee: Mariann Nursing Home and Residence	
Long Term Care Home and City: Mariann Home, Richmond Hill	
Lead Inspector Maria Paola Pistritto (741736)	**Inspector Digital Signature** Maria P Pistritto Digitally signed by Maria P Pistritto Date: 2023.12.11 15:36:16 -05'00'
Additional Inspector(s) Lucia Kwok (752) was present.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 30, 31 and November 1, 2, 2023

The following intake(s) were inspected:

- One intake related to a fall with injury.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

1) The licensee has failed to ensure that the care set out in the plan of care for a resident was provided related to their falls prevention intervention.

Rationale and Summary

A Critical Incident Report (CIR) was received by the Director for a fall with injury. The fall occurred while staff was collecting report. At the time of the fall the identified falls intervention was not used. Personal Support Worker (PSW) #100 confirmed that the falls intervention was to be used for the resident.

The plan of care identified the falls prevention. The care plan identified the resident as a high risk for falls since admission. Progress notes confirmed the resident has a history of falls since their admission. PSW #100 and Registered Practical Nurse (RPN) #103 confirmed the falls intervention was implemented for the resident and was consistently used when the family was not present.

Failure to not implement falls interventions as specified in the care plan contributed to the injuries sustained by the resident.

Sources: Resident's clinical documentation and interviews with staff. [741736]

Non-compliance with: FLTCA, 2021, s. 6 (7)

2)The licensee has failed to ensure that the care set out in the plan of care for a resident was provided related to their falls prevention intervention.

Rationale and Summary

A Critical Incident Report (CIR) was received by the Director for a fall with injury. The fall occurred while staff was collecting report. The plan of care identified a specific falls intervention. The care plan identified the resident as a high risk for falls since their admission date.

Inspector # 741736 observed the resident in the common area with the falls intervention being used incorrectly. On another day, Inspector #741736 observed the resident without their falls intervention in place. RPN #103 confirmed the incorrect use of the falls intervention.

Failure to ensure appropriate fall prevention intervention was in place puts the resident at risk for falls.

Sources: Resident's care plan, observations, and interviews with staff. [741736]

WRITTEN NOTIFICATION: POLICY TO MINIMIZE RETRAINING OF RESIDENTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA 2021, s. 33 (1) b

The licensee has failed to implement the home's policy by collecting documented consent for personal assistive service device (PASD) is to be received prior to applying a PASD for the resident.

Rationale and Summary

A Critical Incident Report (CIR) was received by the Director for a fall with injury. The resident was identified as a high falls risk with a history of falls.

Progress notes identified a specific falls intervention was firstly implemented for the resident's safety. RPN #103 confirmed no documented consent for the falls intervention as a PASD could be produced. Registered staff received verbal consent from family to implement the PASD as a falls intervention. As per the home's policy titled, Use of Personal Assistive Service Devices (PASD), which states that documented consent was required prior to application of the PASD.

Failure to have documented consent puts the resident's rights at risk.

Sources: Resident's progress notes, Use of Personal Assistive Service Devices (PASD) Policy # 05-03-02, last revised March 2021 and interview with staff. [741736]